UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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THOMAS PAYNE,

Plaintiff,

CASE NO.: 1:08-CV-01933 KMK

PLAINTIFF'S AUTOMATIC DISCLOSURE PURSUANT TO FRCP 26 (A)(1)

-against-

DEMPSEY PIPE & SUPPLY, INC.
and MARK WILLIAMS,

Defendants.
----------X

Plaintiffs, by their attorneys Goldblatt & Associates, P.C. as and for their Response To Discovery & Inspection Demands, respectfully sets forth as follows:

1: WITNESSES: Other than the parties themselves and those people listed in the police report plaintiff is aware of the following eye witnesses: William Bitsko; Wade Petrowski, Wyde Lumber Company, Route 17B, Monticello, New York; Kristen Payne, 1225 Rio Grande Drive, Allen, TX 75013; Plaintiff is also aware of the following witnesses to plaintiff's economic damage (e.g., pain and suffering, etc.): Paula Pettigrew, 5211 Vanderbilt Avenue, Dallas, Texas 75206; Brian Stingfellow, 18204 Muir Circle, Dallas, Texas 75287; Don Emillio; Doug Floor.

2: PARTY STATEMENTS: None.

3: PHOTOGRAPHS: Plaintiff is not in possession of any photographs depicting the vehicles or the site of the accident.

4: MEDICAL PROVIDERS: Enclosed as Exhibit A, please find authorizations and an executed power of attorney permitting you to obtain records from the following health care providers:

Plaintiff, Thomas Payne, was treated by the following healthcare providers: **Catskill Regional Medical Center,** 68 Harris Bushville Road, Harris, New York 12742; **Southwestern Neuroscience, Erwin Cruz, M.D., (Dallas Headache Institute)** 12800 Preston Road, Suite 101, Dallas, TX 75230**; Advance Medical Imaging,** 12800 Preston Road, Suite 100, Dallas, TX 75320; **Baylor Rehabilitation System,** 3505 Gaston Avenue, Dallas, TX 75246; **Dr. Michael Taba**, 12800 Preston Road, Dallas, TX 75246 and **Dr. Henry Rarogue**, 701 Tuscan Drive, Suite 280, Las Colinas, Irving, TX 75039. **Sullivan County Radiology Assoc**. P. O. Box 1496 Monticello, New York 12701. **Emergency Medical Association of New York** for services at Catskill Regional Medical Center. **Mobilemedic division of Sullivan Paramedicine**, Inc., P. O. Box 1, Hurleyville, New York 12747 (ambulance service) . **Clinical Pathology Laboratories**, P. O. Box 141669, Austin, Texas 78714.

5: EXPERTS: Those health care provides who have rendered treatment and/or with whom plaintiff has consulted for injuries sustained in this accident and whose medical records and/or reports and/or authorization form has been exchanged. Plaintiff reserves the right to supplement this response until thirty (30) days before the trial of this action.

6: COLLATERAL SOURCE: Annexed hereto as Exhibit B is an authorization permitting defendant to obtain records from **State Farm Insurance Companies**, P. O. Box 799011, Dallas, Texas 75379-9011 claim # 43S59856; **Humana**, P. O. Box 14601, Lexington, KY 40512-4601. Group # N6940034 City of Dallas Health Plan. I.D. #: H00175643; **United**

Healthcare Insurance Company, Springfield Service Center, P. O. Box 30555, Salt Lake City, UT 84130-0555. Member number 927443098.

7. ACCIDENT/INCIDENT REPORTS: Annexed hereto as Exhibit C is a copy of the police report relative to the subject occurrence.

Dated: June 5, 2008
Mohegan Lake, New York

Yours etc.

Goldblatt & Associates, P.C.
By: _____
Kenneth B. Goldblatt, Esq.
Attorneys for Plaintiff(s)
1846 East Main Street (Route 6)
Mohegan Lake, New York 10547
(914) 788-5000

To:

Maynard, O'connor, Smith & Catalinotto, LLP
Michael Catalinotto, Jr.
P.O. Box 180
Saugerties, NY 12477
845-246-3666

POWER OF ATTORNEY

DURABLE SPECIFIC POWER OF ATTORNEY AUTHORIZING AN ATTORNEY REPRESENTING THOMAS PAYNE TO EXECUTE A WRITTEN REQUEST FOR INFORMATION TO OBTAIN MEDICAL, EMPLOYMENT, SCHOOL, TAX AND INSURANCE RECORDS

THE POWERS YOU GRANT BELOW CONTINUE TO BE EFFECTIVE SHOULD YOU BECOME DISABLED OR INCOMPETENT

(CAUTION: THIS IS AN IMPORTANT DOCUMENT. IT GIVES THE PERSON WHOM YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION TO OBTAIN YOUR MEDICAL RECORDS WITHOUT ADVANCE NOTICE TO YOU OR APPROVAL BY YOU. THESE POWERS WILL CONTINUE TO EXIST EVEN AFTER YOU BECOME DISABLED OR INCOMPETENT. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.)

THIS is intended to constitute a DURABLE SPECIFIC POWER OF ATTORNEY to execute a written request for patient information to obtain his or her medical records pursuant to Section 18 of the New York Public Health Law:

I, { THOMAS PAYNE }do hereby appoint the law firm of {GOLDBLATT & ASSOCIATES, P.C. 1846 EAST MAIN STREET (ROUTE 6) MOHEGAN LAKE, NEW YORK 10547}.

IN MY NAME, PLACE AND STEAD in any way which I myself could do, if I were personally present, with respect to the executing of a written request for patient information to obtain my any and all of my medical records to the extent that I am permitted by law to act through an agent.

This durable Power of Attorney shall not be affected by my subsequent disability or incompetence.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY UNLESS AND UNTIL ACTUAL NOTICE OR KNOWLEDGE OF SUCH REVOCATION OR TERMINATION SHALL HAVE BEEN RECEIVED BY SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE SPECIFIC POWER OF ATTORNEY WITH RESPECT TO THE EXECUTING OF A WRITTEN REQUEST FOR PATIENT INFORMATION TO OBTAIN ANY AND ALL OF MY MEDICAL RECORDS MAY BE REVOKED BY ME AT ANY TIME.

In Witness Whereof I have hereunto signed my name this 23rd day of July, 2007
(YOU SIGN HERE==> _____
{PRINCIPAL NAME} THOMAS PAYNE

THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

On the 23rd day of June, 2007, before me personally came { THOMAS PAYNE }, to me known to be the individual described in and who executed the foregoing instrument and acknowledged that executed the same.

_____
NOTARY PUBLIC Kenneth Goldblatt
Notary Public State of New York
No. 02GO6021933
Qualified in Westchester County
Commission Expires March 22, 2008

AFFIDAVIT OF SERVICE BY MAIL

STATE OF NEW YORK)
) SS.
COUNTY OF WESTCHESTER)

I, Jennifer Rath, being duly sworn, states the truth of the following:

I am not a party to this action. I am over 18 years of age and reside in the County of Westchester. On Friday, June 06, 2008, I served the within Plaintiff's Automatic Disclosure Pursuant to FRCP 26 upon:

Maynard, O'connor, Smith & Catalinotto, LLP

Michael Catalinotto, Jr.

P.O. Box 180

Saugerties, NY 12477

by regular mail by depositing a copy of the same in a post-paid wrapper labeled with the address designated by said party or parties for this purpose, in an official Post Office depository located in the State of New York, and under the exclusive control of the United States Postal Service.

Jennifer Rath

Jennifer Rath

Sworn to before me this
6th day of June 2008

Notary Public

Kenneth B. Gonzalez
Notary Public State of New York
No. 02GO6021933
Qualified in Westchester County
Commission Expires March 22, 20[illegible]

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Sullivan County Radiology Associates
P. O. Box 1496
Monticello, New York 12701

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

The type and amount of information to be used or disclosed is as follows:
The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquitted immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

This authorization shall remain in full force and effect until it **expires one year** from the date set forth below.

I understand that I have the **right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Sullivan Paramedicine, Inc.
P. O. Box 1
Hurleyville, New York 12747

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

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Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
United Health Care Insurance
Springfield Service Center
P. O. Box 30555
Salt Lake City , UT 84130-0555

MEMBER #: 927443098

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 TO DATE**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Michael Taba, M.D.
12800 Preston Road
Dallas, Texas 75230

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, , for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

The type and amount of information to be used or disclosed is as follows:
The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

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Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Henry Raroque, M.D.
Southwestern Neuroscience Institute
701 Tuscan Drive
Suite 280
Irving , Texas 75039

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquitted immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

This authorization shall remain in full force and effect until it **expires one year** from the date set forth below.

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Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Carie Foret
State Farm Insurance
17301 Preston Road
P.O. Box 799011
Dallas , Texas 75379
No Fault Claim No.:43S598456

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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Dated :June 05, 2008

Goldblatt & Associates, P.C.
Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Erwin Cruz, M.D.
12800 Preston Road
Suite 101
Dallas , Texas 75230

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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Dated :June 05, 2008
Goldblatt & Associates, P.C.

_____
Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Advanced Medical Imaging
12800 Preston Road
Dallas , Texas 75230

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

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I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquitted immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

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I understand that I have the **right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

Dated :June 05, 2008

Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Catskill Regional Medical Center
68 Harris Bushville Road
Harris , New York 12742

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

The type and amount of information to be used or disclosed is as follows:
The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquitted immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

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Dated :June 05, 2008
Goldblatt & Associates, P.C.

_____
Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Baylor Hospital Institute for Rehabilitation
3505 Gatson Avenue
Dallas, TX 45246

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

This authorization shall also serve to permit a representative from the law firm of Maynard, O'connor, Smith & Catalinotto, LLP to conduct a personal review of all medical information that you may have pertaining to the patient named above , but you are not permitted to orally discuss this information with any such representative.

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The complete medical chart/record of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

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Dated :June 05, 2008
Goldblatt & Associates, P.C.

Goldblatt & Associates P.C. as per Power of Attorney

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:
Clinical Pathology Laboratories
P. O. Box 141669
Austin, Texas 78714

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION*
***Compliant with HIPAA**

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

TO:

Humana
P. O. Box 14601
Lexington, KY 40512-4601

GROUP # N6940034
City of Dallas Health Plan
I.D. # H00176543

PATIENT NAME: Thomas Payne **SS#: 122-48-5569**

DATE OF BIRTH: October 21, 1956 **DATES OF TREATMENT: 7/11/05 to date**

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipient Maynard, O'connor, Smith & Catalinotto, LLP, for the purpose of: **At the request of the individual**.

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Dated :June 05, 2008

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